Cover page	
Meeting	**Trust Board**
Paper Title	Quality Governance Report
Date of meeting	3rd October 2019
Date paper was written	12th September 2019
Responsible Director	Barbara Beal, Director of Nursing, Midwifery and Quality
Author	Peter Jeffries, Associate Director of Quality, Governance and Risk
Previously considered by	N/A

The Board is asked to:			
☐ Approve	☑ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☐ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	**BAF 1134:** We need to deliver plans jointly agreed with the local health and care system so our admission and discharge processes ensure patients are receiving safe and effective care in the right place **BAF 1533:** We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients **BAF 1204:** Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)

Freedom of Information Act (2000) status	(•) This document is for full publication ( ) This document includes FOIA exempt information ( ) This whole document is exempt under the FOIA
Financial assessment	N/A

Main Paper

Situation

The purpose of this report is to provide Trust Board with assurance relating to our compliance with quality performance measures during August 2019.

Background

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of August 2019. The report will provide assurance to the Quality and Safety Assurance Committee where we are compliant with key performance measures and outline areas where further assurance may be required.

Assessment

Key points to note by exception:

- VTE assessment compliance in June (latest available validated figures) remains below the 95% target. VTE is subject to an action plan under the leadership of the Medical Director outlined to committee under the Clinical Governance Executive update;
- An increase in reported C-Diff cases linked to wards 7, 16 and 27. A patient identified with C-diff linked to ward 7 in August has since died with C-Diff noted on part 1a of the death certificate this has been raised as a serious incident and will be fully investigated (SI raised in September);
- Three serious incidents two relating to diagnostic delays and one to endoscopy washer disinfectors;
- One patient fall raised as a High Risk Case Review in August;
- Two grade three pressure ulcers raised as High Risk Case Reviews in August

Recommendation:

Trust Board are asked to:

- Discuss the current performance in relation to key quality indicators as of August 2019;
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place

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Quality Governance Report September 2019

INTRODUCTION

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of August 2019. The report will provide assurance to the Quality and Safety Committee where we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place.

The report will be submitted to the Quality and Safety Committee as a standalone document and will then be presented to Trust Board as part of the integrated reports for consideration and triangulation with performance and workforce indicators.

This report relates to the Care Quality Commission (CQC) domains of quality – that we provide safe, caring, responsive and effective services that are well led, as well as the goals laid out within our organisational strategy and our vision to provide the safest, kindest care in the NHS.

CONTENTS

Section one: Our Key Quality Measures – how are we doing?

Measure	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
CDI due to lapse in care (CCG panel)	2	1	1	1				1	1	2			5	2	43
Total CDI reported	2	1	1	2	1	2	1	2	3	7	5	6	23	2	43
MRSA Bacteraemia Infections *Contaminant	0	0	1*	1*	0	0	0	0	1	0	0	0	1	0	0
MSSA Bacteraemia Infections	3	1	2	1	5	0	0	1	1	3	4	3	12	None	None
E. Coli Bacteraemia Infections	3	7	8	5	2	3	3	3	9	3	2	4	17	None	None
MRSA Screening (elective) (%)	97.6%	95.4%	95.9%	95.2%	96.5%	96.1%	95.6%	95.9%	91.8%	95.9%	95.6%	96.1%	95.1%	95%	95%
MRSA Screening (non elective) (%)	96.7%	96.5%	97.1%	97.0%	96.8%	96.5%	96.4%	96.4%	95.9%	94.3%	95.7%	95.5%	95.5%	95%	95%
Cat 2 Confirmed	15	7	12	10	11	14	16	15	10	12	8	3	48	None	None
Cat 2 Reported	15	7	12	10	11	14	16	18	15	18	14	21	86	None	None
Cat 3 HRCR	4	0	4	3	6	9	3	2	1	0	1	2	6	None	None
Cat 3 Serious Incident	0	0	0	0	0	0	0	0	0	0	0	0	0	None	None
Cat 4 HRCR	0	0	0	0	0	0	0	1	0	0	0	0	1	None	None
Cat 4 Serious Incident	0	1	0	0	0	0	1	0	0	0	0	0	0	None	None
Falls reported as serious incidents	0	0	0	0	0	0	2	0	1	0	1	0	2	None	None
Number of Serious Incidents	2	3	4	3	1	1	5	3	2	3	2	3	13	None	None
Never Event	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Catheter Associated UTI (number of patients on prevalence audit)	3	2	6	0	*	1	0	*	3	1	2	0	6	None	None
WHO Safe Surgery	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

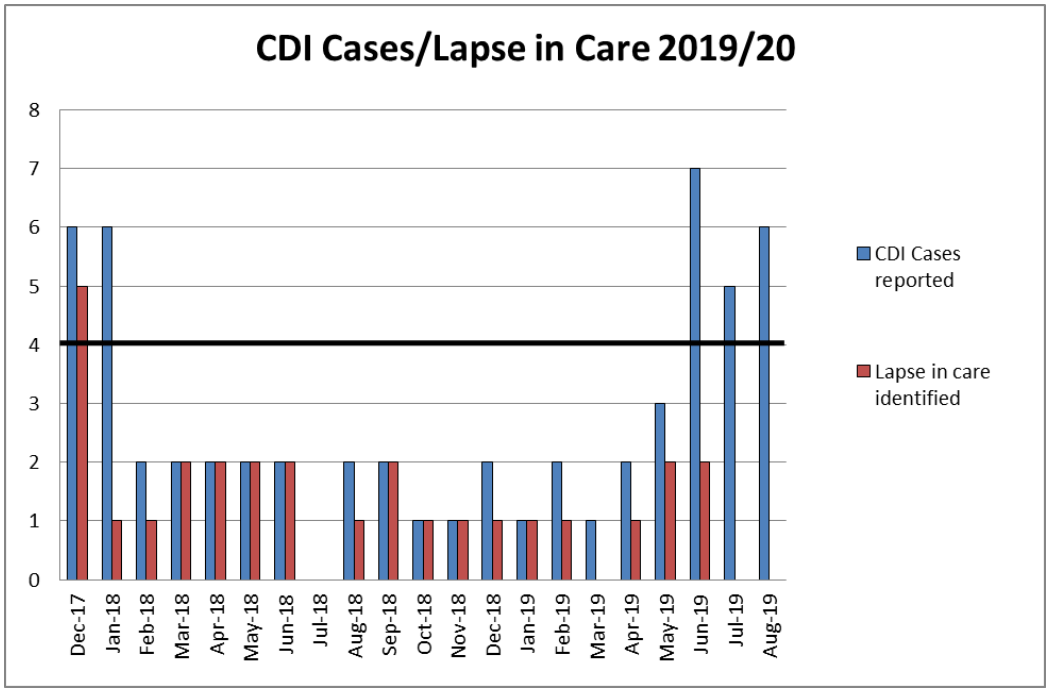
Measure	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	June 19	July 19	Aug 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
Checklist (%)															
VTE Assessment	96.0%	97.3%	95.9%	95.1%	94.4%	94.2%	94.2%	93.7%	94.3%	94.4%			94.1%	95%	95%
ITU discharge delays>12hrs	46	40	30	42	30	24	26	37	27	43	36	24	167	None	None
No of MSA breaches other areas	0	0	0	0	0	0	0	0	0	0	0	0	0	None	None
Complaints (No)	58	55	82	40	53	50	64	59	65	55	63	72	314	None	None
Friends and Family Response Rate (%)	16.5%	14.6%	16.7%	11.4%	11.3%	11.5%	9.3%	10.5%	11.5%	11.3%	15.2%	15.1%	12.7%	None	None
Friends and Family Test Score (%)	97.1%	97.2%	97.6%	97.4%	97.1%	97.5%	97.5%	97.6%	97.8%	97.8%	96.8%	97.4%	97.6%	95%	95%

Section Two: Key Messages by exception

Infection Prevention and Control

Clostridium Difficile (C Diff)

There were 6 incidents of C diff attributed to the Trust in August 2019. Three of these cases were post 48 hour cases and three had been inpatients in the 28 days prior to their positive sample. These cases are now attributed to the Trust following the recent changes in the reporting guidelines from PHE to be applied as of April 2019, which resulted in the annual target for the Trust increasing to 43.



There have been 4 cases of Clostridium Difficile Infection (CDI) associated with ward 7 (PRH) over a period of 5 months. The 1st case was identified in May 2019, and the 2nd in June 2019. These were investigated as an outbreak. This investigation was completed and actions signed off on 03.09.19. Case 3 was identified in August 2019 & was a pre 48 case which had contact with SaTH in the previous 28 days. Initially the case was attributed to ward 17. During the RCA meeting (held on 04.09) it was identified that the patient had recent contact with ward 7, it was agreed by microbiology that this case was to be attributed to ward 7 therefore the outbreak investigation was reopened & will take place on the 12th September 2019.

A link with a 4th Case to ward 7 was identified on 9th September.

1 of the patients (case 3) who was identified in August has since died with CDI recorded on part 1(a) of the Death Certificate, therefore this has been reported as an SI and is currently being investigated.

August PII/Outbreaks

Ward 16 PRH – ESBL

Two patients linked in time and place on Ward 16 on 16.08.19.

- Immediate control meeting held to identify any issues on 20.08.19
- Tristel cleaning was commenced on 16.08.19.
- Weekly Quality Ward Walks were carried out for 3 weeks; to identify any issues. The ward has scored above 90% on each audit
- Typing results came back as same type therefore it was declared as an outbreak on 02.09.19.
- A second outbreak meeting has been requested and is currently being arranged.

Ward 27SD RSH – C-Diff

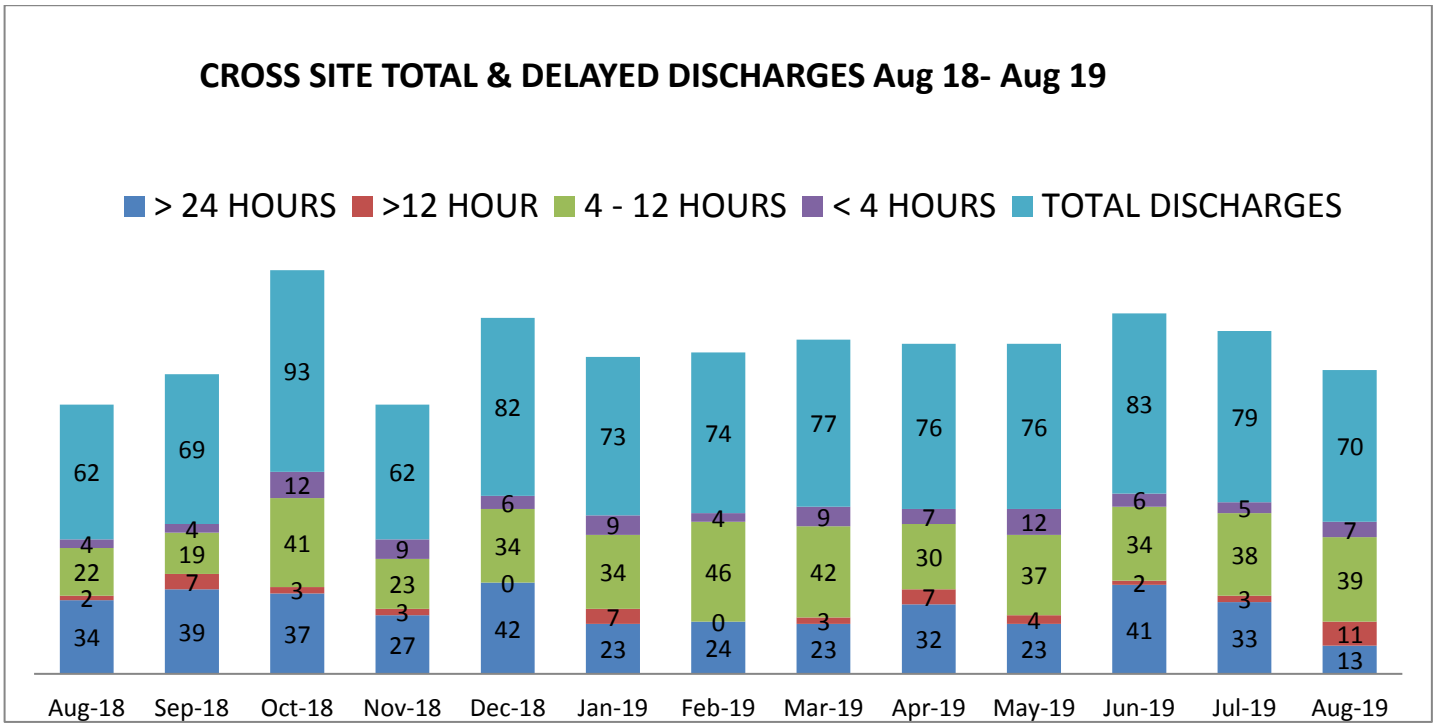
Two patients linked in time and place to Ward 27SD on 27.08.19.

- Immediate control meeting held to identify any issues on 30.08.19.
- Tristel cleaning was commenced on 27.08.19.
- Weekly Quality Ward Walks to be carried out for 3 weeks.
- The ward has scored below 90% on the two audits so far. Issues found were lack of single use BP cuffs in isolation rooms, inappropriate use of skips
- An action plan has been developed and IPC are working with the ward manager to rectify the issues that were brought up from the Quality ward walks.
- Awaiting results from typing which were requested on 27.08.19, therefore this is not a confirmed outbreak

Complaints & PALS

72 formal complaints were received, in line with expected variation; 38 related to RSH and 34 related to PRH. There has been an increase in complaints within Scheduled Care; these are primarily about problems with appointments and communication. 177 PALS contacts were received.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches



There were 70 patients in total discharged from critical care in August 2019. 24 of these patients experienced a delayed in discharge of >12 hours from Critical Care (a reduction from previous month). With a further 12 patients experienced a mixed sex accommodation breach – 11 patients from ITU/HDU at The Royal Shrewsbury Hospital and 1 patients from ITU/HDU The Princess Royal Hospital. These figures are similar to the previous month.

Friends and Family Test

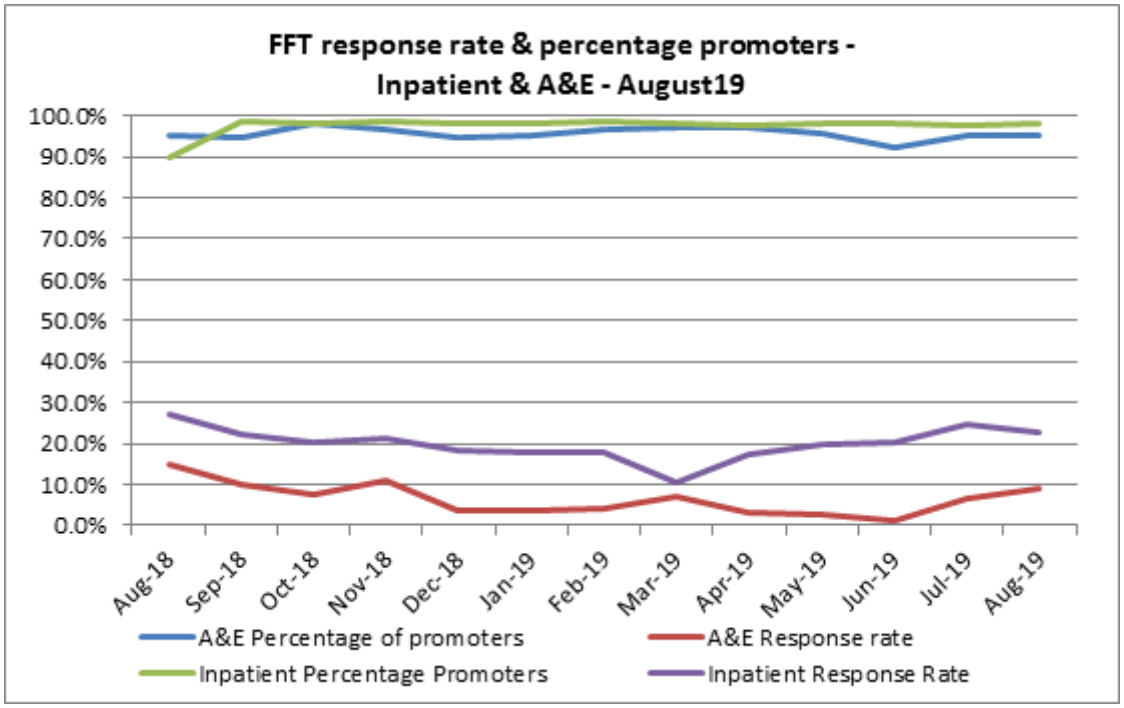
The overall percentage of August patients who would recommend the ward they were treated on to friends and family, if they needed similar care and treatment was 97.4%; which was an increase compared to July. Individually, Inpatient, Maternity and Outpatients all increased and A&E remained the same as July.

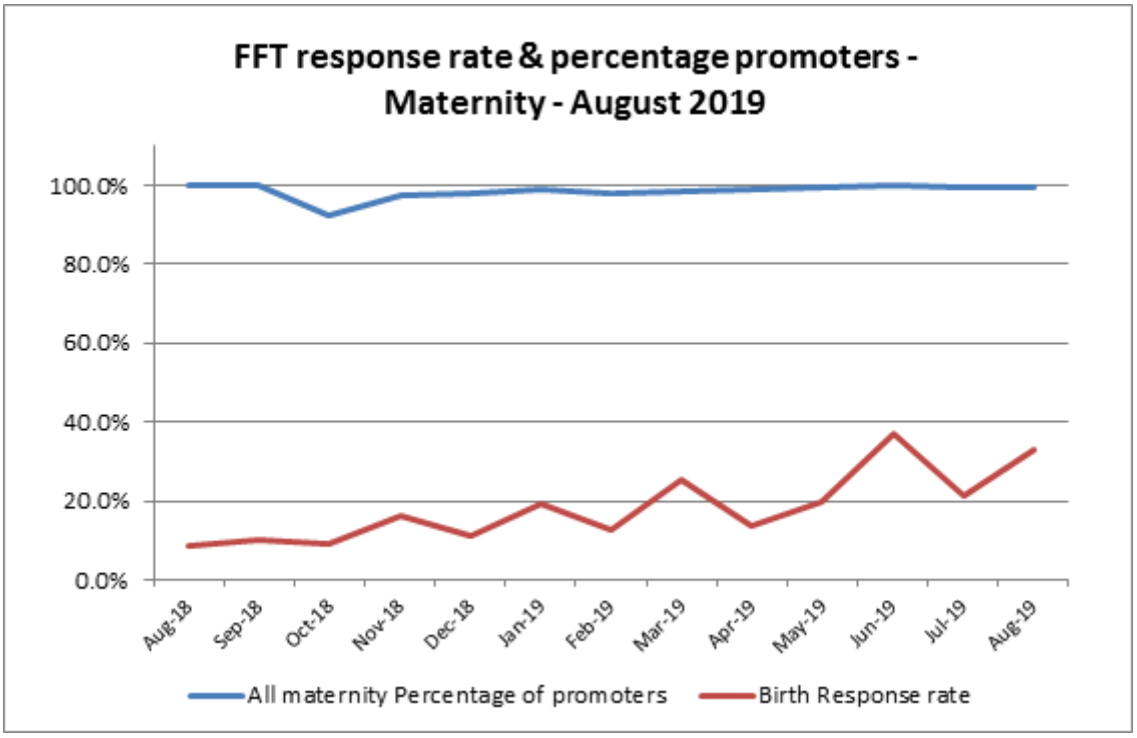
The overall response rate this month was 15.1% which was just a 0.1% decline compared to July. A&E response rate increased from 6.6% in July to 8.8% in August. The inpatient and Maternity response rated dropped compared to July.

The overall data for August 2019 is as follows:

The FFT response rate = 15.1%
The FFT percentage of recommenders = 97.4%

	Percentage of Recommenders	Response Rate
Inpatient	98.3%	22.6%
A&E	95.3%	8.8%
Maternity overall	99.6%	15.1% (Birth only)
Outpatients	97.0%	NA

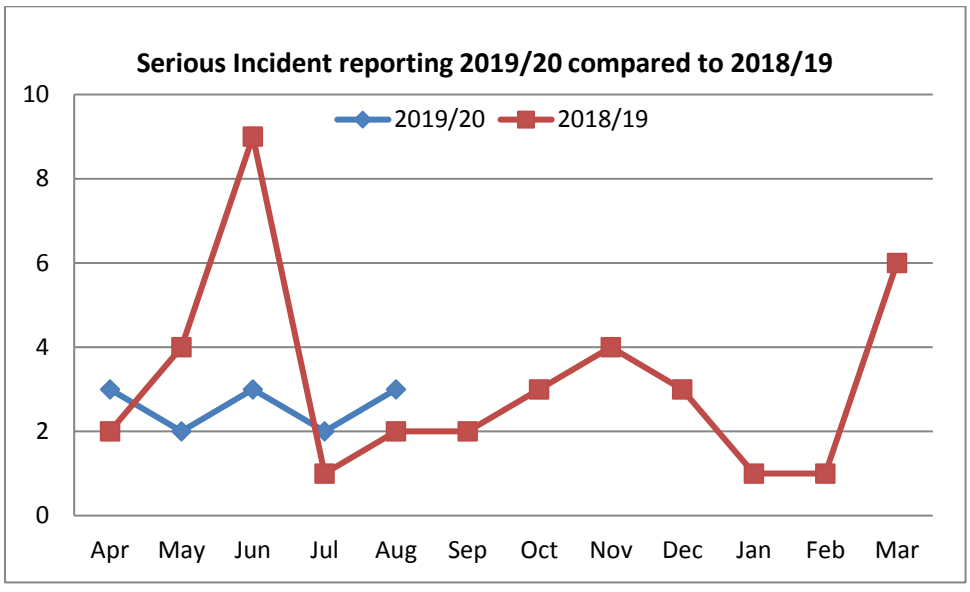




Serious incidents

In August 2019we reported three serious incidents as shown in the chart below and overall reporting numbers are lower in 2019/20 when compared to the same reporting period for 2018/19

Serious incident reporting 2019/20 compared to 2018/19



The categories of incident are shown in table one below:

Table one: Categories of incidents reported in July 2019

Category	Number
Major incident /suspension of services	1
Diagnostic Delay	2
Total	**3**

Major Incident/Suspension of Services

26/07/2019 – Environmental Mycobacterium test results received by Trust from 20/30 Labs relating to endoscope washer-disinfector (210-140). The results indicated raised levels of mycobacterium of 97 cfu/100ml (left tank) and >100cfu/100ml (right tank). HTML 01-06 states that a satisfactory result is for no mycobacterium to be detected in a 100ml sample.

Results were not acted on and the washer continued to be used until the situation was identified on 01/08/2019.

Diagnostic Delay (1)

April 2015: A patient attended for Oesophageal Gastro Duodenoscopy (OGD) for Barrett's surveillance. 4 biopsies were taken and the histology results indicated – Features of Barrett's Oesophagus with low grade dysplasia.

July 2015: A further OGD was carried out and a further 4 biopsies taken. Histology indicated– Appearances of Barrett's oesophagus with gastric metaplasia, no evidence of dysplasia or malignancy. A repeat OGD after one year was planned.

Sept 2016: A further surveillance OGD was carried out and 6 biopsies taken. Histology indicated – Some reactive changes with intestinal metaplasia and architectural distortion. These changes represent low grade atypia and as such the features are those of Barrett's oesophagus with atypia. Due to this result it was deemed that there had been no worrying changes to the cells and a repeat OGD in 3 years was advised. (Due Sept 2019)

Jan 2019: The patient became symptomatic of abdominal discomfort, tiredness, anorexia. Following an urgent referral a further OGD was carried out, specimens taken and adenocarcinoma identified.

Current review has identified that the terminology of 'atypia' was not understood consistently. For pathology the inference was that there were changes and the patient needed to stay under surveillance, for The British Society of Gastroenterology (BSG) and the gastroenterology team, the standard language was; dysplasia. As a remedial action; pathology has ceased using the term 'atypia'.

Diagnostic Delay (2)

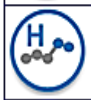
August 2019: A patient was admitted to ED presenting with a 4 day history of Left upper quadrant abdominal pain, with? faecal vomiting (noted in Ambulance Summary and initial Nurse Assessment). Patient had a past medical history of diverticulitis. The ambulance summary stated an impression of Diverticulitis/Obstruction.

In ED the patient's observations were taken; EWS score was 0. Patient seen by a doctor and a differential diagnosis of ?gastritis or ?constipation was made. Patient was administered Morphine for pain relief, Ondansetron (anti-emetic) Lactulose and Diclofenac. Discharged without radiological assessment.

9 days later the patient re-presented in ED with an EWS of 7. Investigations indicated caecal perforation as a result of a bowel obstruction. Patient underwent a laparotomy and subtotal colectomy to remove the bowel obstruction and the perforated bowel. Patient was haemodynamically unstable during the operation, and was transferred to the Intensive Care Unit postoperatively. Remained unstable despite maximal ICU care and died approximately 28 hours after the surgery.

This incident has been raised as an SI as it may be possible that had further investigations taken place on the patient's initial attendance at ED (abdominal x ray/ CT scan), in light of symptoms of (? faecal vomiting), the obstruction may have been diagnosed earlier and the sad outcome may have been different for the patient.

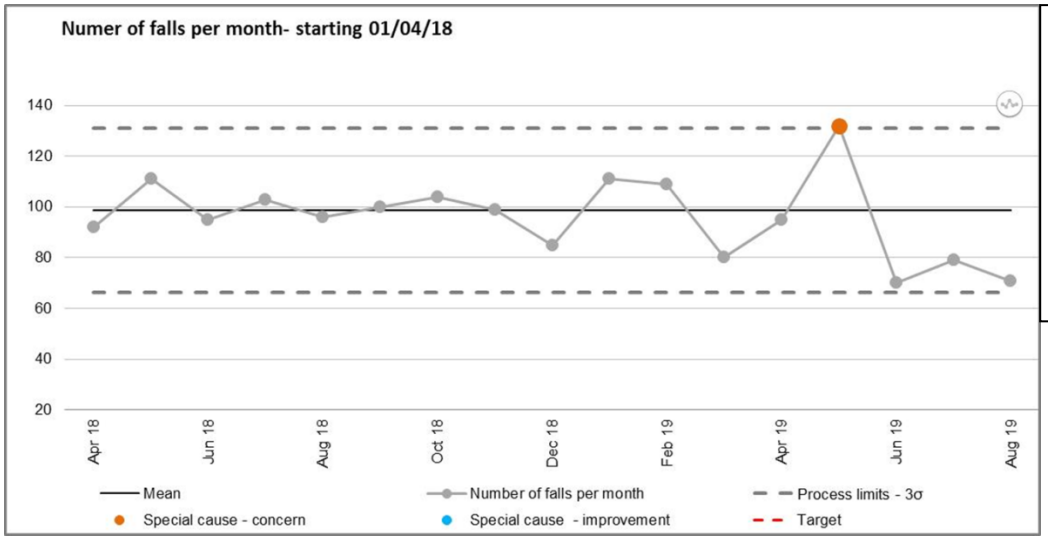
Patient Falls

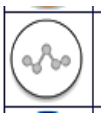
Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

For the September 2019 Quality Governance report data relating to patient falls is being presented in the format of statistical process control (SPC) charts generated via the NHSI SPC tool.

The SPC charts below include icons aligned with the key to the left. These icons indicate key messages about systems performance based on the SPC charts. Additional concise summary text is also included to describe systems performance and any key points to note.

Total number of falls: April 2018- August 2019





Common cause variatic

Total number of falls demonstrates common cause variation.

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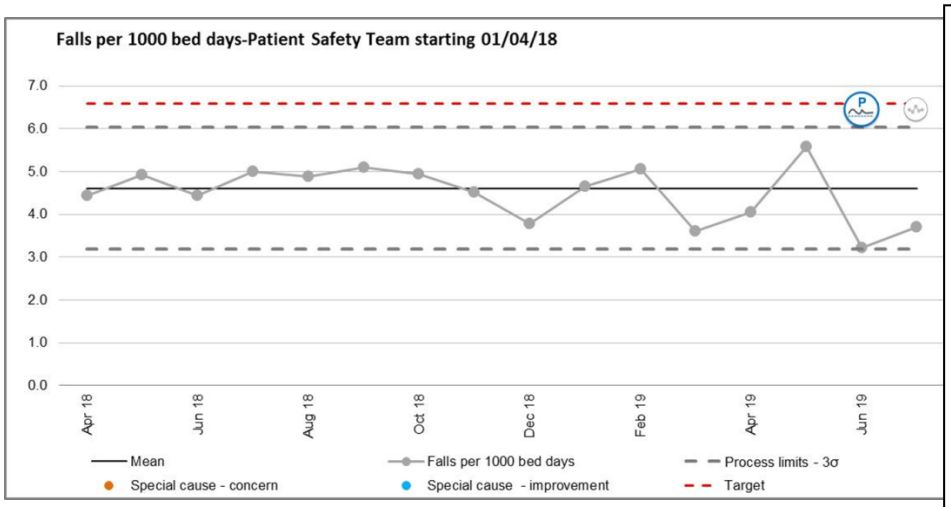
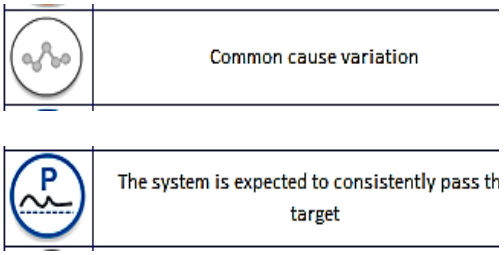
Falls per 1000 bed days: April 2018-August 2019

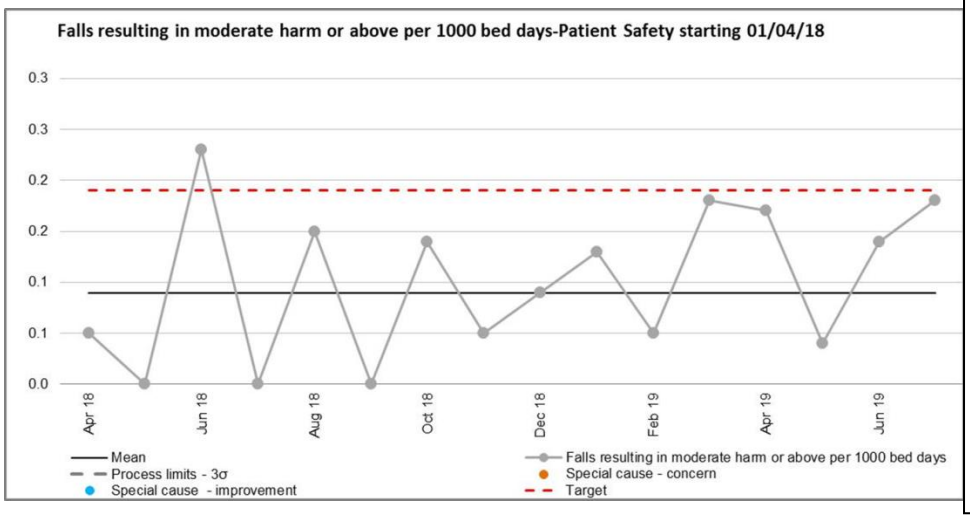


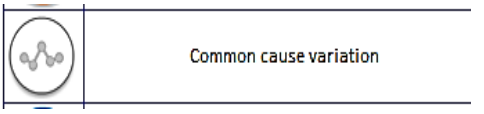


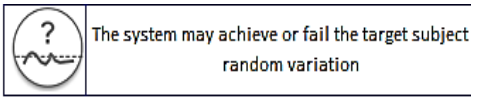
Falls per 1000 bed days demonstrates common cause variation.

The system is expected to consistently meet the benchmark target of 6.6 falls per 1000 bed days within common cause variation.

Falls per 1000 bed days resulting in moderate harm or above: April 2018-August 2019







Falls per 1000 bed days resulting in moderate harm of above demonstrates common cause variation.

It is possible within common cause variation the system may occasionally exceed the benchmark target of 0.19 per 1000 bed days (as demonstrated in June 2018).

In August 2019 there were no falls reported which required reporting as Serious Incidents and one fall which resulted in a fracture which was determined to be suitable to manage as a High Risk Case Review:

High Risk Case Review

Fall injury	Rationale for not reporting as an SI
#NOF (Ward 26)	Patient has full capacity and was independently mobile requiring the aid of a walking stick prior to fall. All risk assessments were completed appropriately pre-fall. The patient mobilised independently and turned to pass a magazine to the patient in the next bed, as she turned she lost balance and fell. A HCA was stood near to the patient at the time and witnessed her loosing balance, the HCA managed to reach the patient to try and guide her fall, but unfortunately fell with the patient.

Hospital Acquired Pressure Ulcers

In August 2019 there were two category 3 pressure ulcers which were deemed appropriate to manage as High Risk Case Reviews.

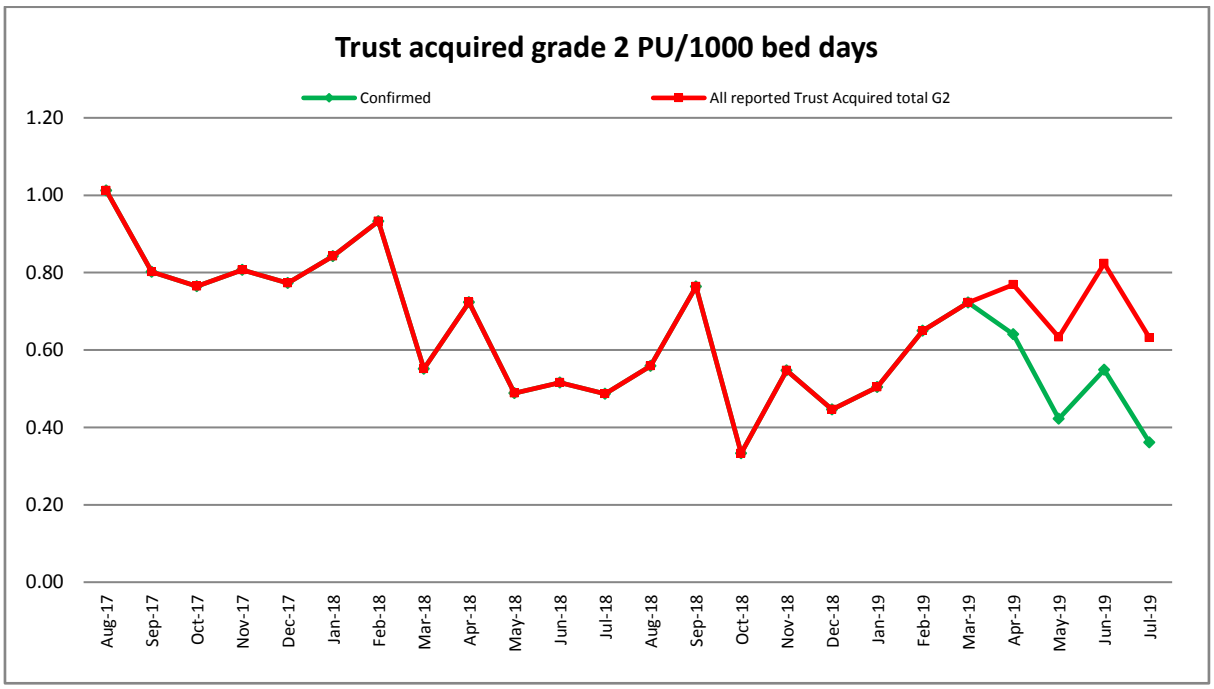
High Risk Case Review (HRCR) Pressure Ulcers August 2019

Category 3 –	W23	Waterlow and nutritional scores were always in date and accurate and review confirmed all policies and procedures were followed. Patient was end of life.
Category 3 –	AMU	Patient admitted to the organisation with moisture damage which deteriorated to small areas of category 3/moisture combination skin damage. Consideration is being given to length of time the patient was on a trolley in ED which may have contributed to the deterioration.

Of the 21 reported category 2 pressure ulcers, three have been confirmed; the reviews identified that there were no specific themes. The outcome/learning identified was;

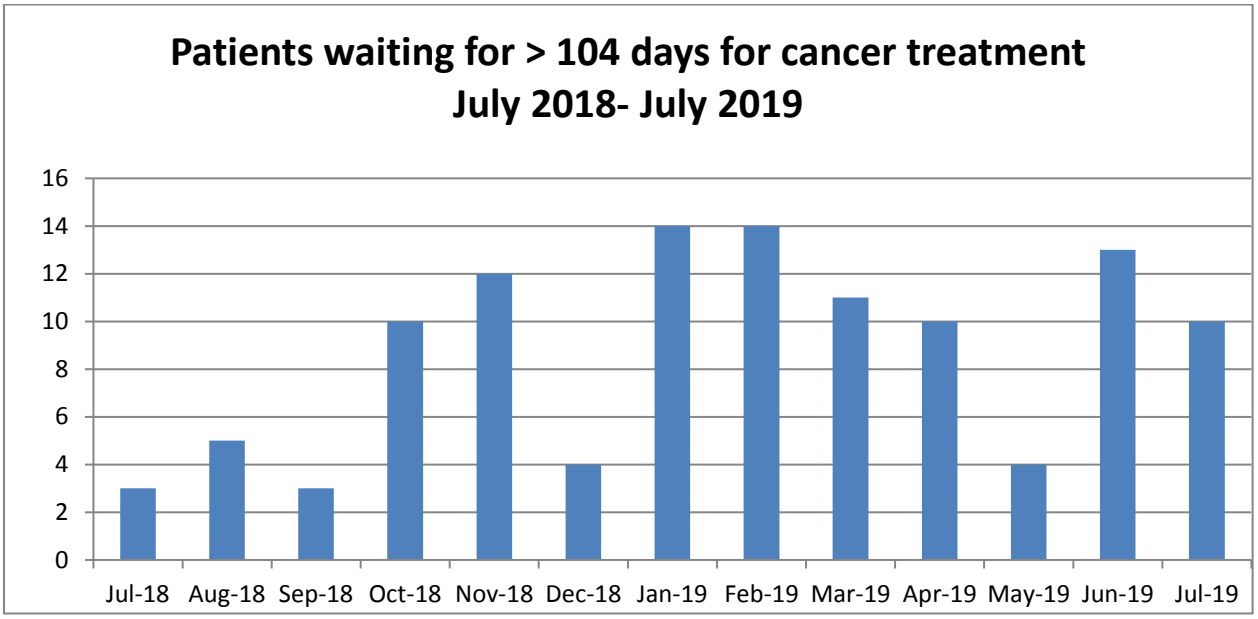
- Complete risk assessments within timescales
- Improved documentation on top to toe charts (inconsistencies noted)
- Appropriate care and monitoring was in place, could be trauma from tape.

The numbers of Trust acquire category 2 pressure ulcers that we are reporting are shown below when reviewed in terms of incidents per 1000 bed days.



Waiting for cancer treatment for more than 104 days

In July 2019 10 patients waited more than 104 days for cancer treatment.



The reasons for the breach and cancer pathway for the patients who waited more than 104 days for treatment are outlined below:

Pathway	Number of Days	Reason for breach
Lung	115	Patient choice – patient declined investigations and treatments
Lung	120	Treatment delay for medical reasons
Lung	129	Patient choice- patient not engaging with pathway (significant mental health issues)
Skin	112	Patient choice – patient on holiday delaying confirmation of treatment
Upper GI	126	Complex pathway – initial referral to colorectal
Urology	142	Elective capacity (prostatectomy)/diagnostic delay
Urology	126	Delay for diagnostics / complex pathway
Urology	104	Delay for diagnostics/ out-patient capacity
Urology	169	Elective capacity (prostatectomy)/ delay for diagnostics
Urology	143	Diagnostic delay

Section Three: Mortality Review

Mortality metrics CHKS June 2018 – May 2019

Description	Local Numerator	Local Denominator	Jun 18 - May 19	Jun 17 - May 18	Change	Peer Value	Performance
Mortality Rate	1627	168338	0.9665%	1.1649%		1.1494%	
Deaths in Low Mortality CCS Groups	15	12418	0.12079%	0.19200%		0.10673%	
Rate of Mortality in hospital within 30 days of elective surgery	1	3208	0.031172%	0.21433%		0.12981%	
Rate of Mortality in hospital within 30 days of Non elective surgery	85	7896	1.0765%	1.1844%		1.3461%	
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	7	236	2.9661%	4.305%		4.704%	
Rates of mortality in hospital within 30 days of emergency admission with a stroke	107	937	11.419%	10.348%		11.849%	
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	4	314	1.2739%	0.7874%		3.177%	
RAMI (Risk adjusted mortality index) 2018	1627	1887	86.20	89.88		89.46	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018	1627	2808	57.94	64.71		66.33	
SHMI (Summary Hospital-Level Mortality Index) +	1766	1778	99.34	102.59		99	
HSMR (Hospital Standardised Mortality Ratio)	1503	1733	86.74	94.76		91.54	

- Overall the Mortality metrics for the Trust, including HSMR, are within the expected range.

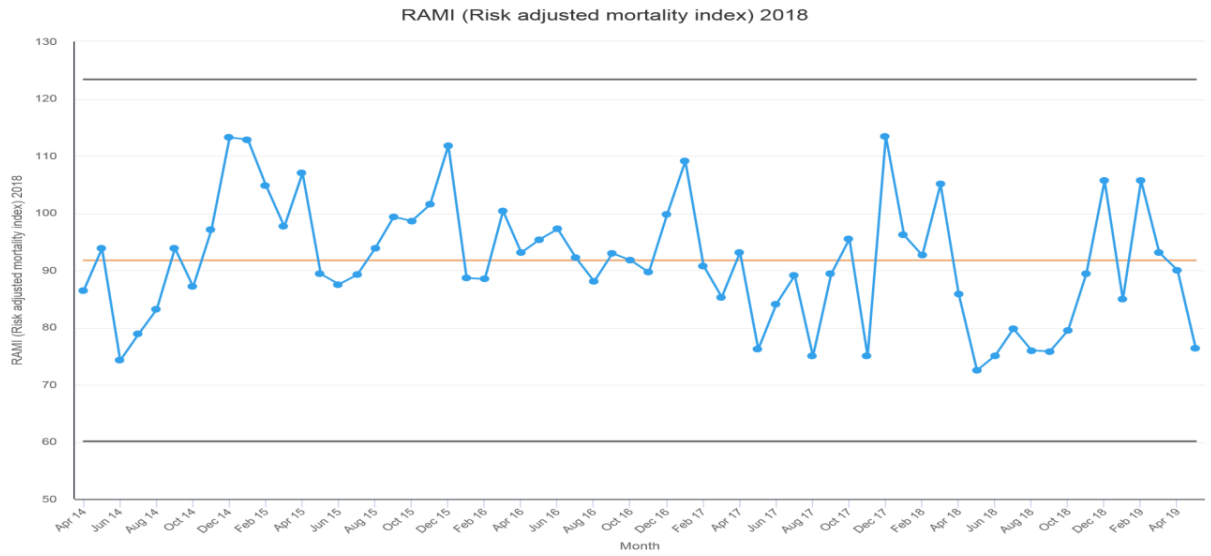
- Although the change in *% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74* is showing a red deterioration on the previous year (Jun 17 – May 18), this data only includes 4 deaths (1.2739%) compared to a peer value of 3.177%, so is still below the expected range.

- The HSMR for the CCS group 'Acute cerebrovascular disease' is starting to show an improvement but SaTH is still a significantly statistical outlier. No external alerts have yet been received by the Trust. This is currently beign investigated and the report into the investigation of this trend is expected in October. This group includes not only Stroke patients admitted to PRH, but also younger patients who suffer spontaneous catastrophic intra-cerebral haemorrhages and who are admitted to RSH.

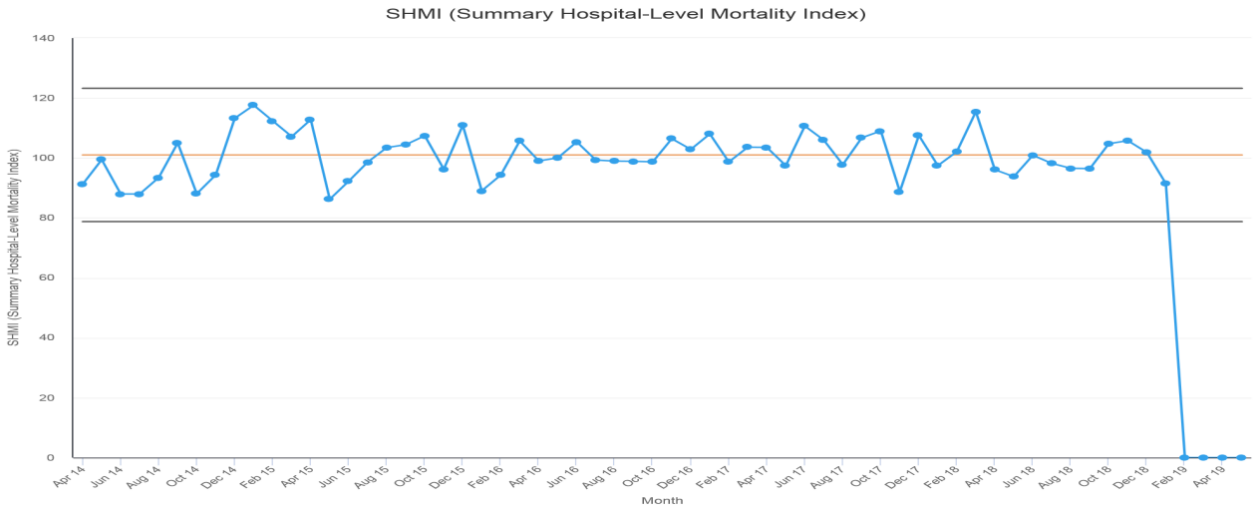
- Action plans continue to be delivered against mortality outliers identified via national audits which are Lung Cancer and fractured neck of femur at PRH. These action plans are being reported and monitored via Care Group Boards, Cancer Board and Clinical Governance Executive and will be reported to Quality and Safety Committee by exception.

Mortality 5 year trend April 2014 to May 2019

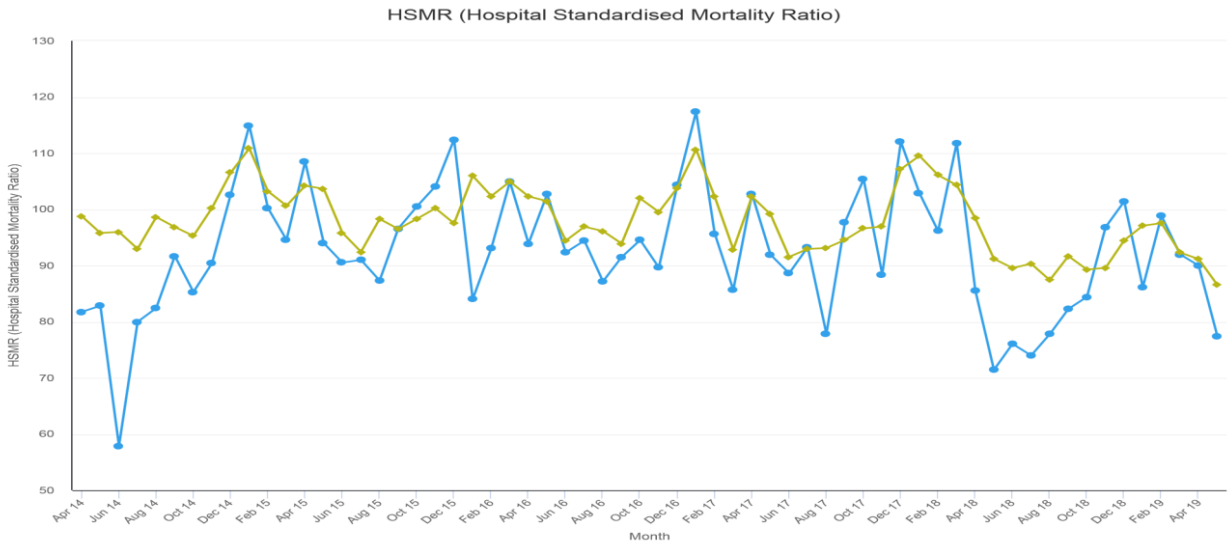
Risk adjusted mortality index (RAMI)



Summary Hospital Level Mortality Index SHMI – (note data only available up to Feb 19)



Hospital standardised mortality ratio (HSMR) - Monthly variation compared to peer average (Trust blue line)



Section Four: Recommendations for the Committee

The Quality and Safety Committee is asked to:

- Discuss the current performance in relation to key quality indicators as at the end of August 2019
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place